

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105960	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Windermere		STREET ADDRESS, CITY, STATE, ZIP CODE 4875 Cason Cove Drive Orlando, FL 32811	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure implementation and performance of appropriate isolation precautions including standard and enhanced precautions for infection prevention and control, for 3 of 3 residents reviewed for transmission-based precautions, of a total sample of 38 residents, (#132, #134, and #5). Findings: 1. Resident #132 was admitted to the facility on [DATE] with diagnoses that include Enterocolitis due to Clostridium difficile, hypertensive chronic kidney disease, adult failure to thrive, immunodeficiency and malignant neoplasm (cancer) of the left kidney. Review of the medical record revealed resident #132 had a current physician order for Contact Precautions. Review of the current Plan of Care reflected an approach for Contact Isolation Precautions as ordered. On 6/15/26 at 11:25 AM, the signage outside resident #132's room indicated the resident was on Contact Precautions. The sign instructed staff to put on gowns and gloves before room entry. Licensed Practical Nurse (LPN) A was observed in resident #132's room without a gown and gloves and upon her exit, she stated she did not need to wear Personal Protective Equipment (PPE) because she was just giving the resident a drink. The nurse explained in the presence of the Staff Educator/Developer nurse who was also the Risk Manager, that she only wore PPE when giving direct care to residents. Contact precautions are intended to prevent transmission of pathogens that are spread by direct (e.g., person-to-person) or indirect contact with the resident or environment (e.g., C. difficile, norovirus, scabies), and requires the use of appropriate PPE, including a gown and gloves before or upon entering (i.e., before making contact with the resident or resident's environment) the room or cubicle. Prior to leaving the resident's room or cubicle, the PPE is removed and hand hygiene is performed, (retrieved on 6/19/26 from State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities). On 6/17/26 at 1:30 PM, in a joint interview with the Director of Nursing (DON), the Infection Preventionist (IP) nurse and the Staff Educator/Risk Manager, they acknowledged the expectation for a resident on contact precautions, was for staff including LPN A to wear the appropriate PPE regardless of the task performed and regardless of whether she provided direct care to the resident to avoid the spread of infectious agents. 2. Resident # 134 was re-admitted to the facility on [DATE] with diagnoses that included malignant neoplasm (cancer) of connective and soft tissue of right lower limb, including hip, osteoarthritis of knee, unspecified; secondary malignant neoplasm of unspecified lung, anxiety disorder and chronic (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105960	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Windermere		STREET ADDRESS, CITY, STATE, ZIP CODE 4875 Cason Cove Drive Orlando, FL 32811	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	viral hepatitis. Review of resident #134's medical record revealed no current orders for isolation precautions. Review of the current plan of care for resident #134 revealed an approach for Contact Isolation precautions as ordered on 6/12/26. On 6/15/26 at 10:06 AM, resident # 134 had an intravenous (IV) midline to his right upper arm and said he received antibiotics through the midline. The resident had a dressing on his right lower leg. No isolation precaution sign was outside the resident's door to indicate to staff or visitors that precautions were needed. Enhanced Barrier Precautions (EBP) expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multi drug resistant organisms (MDRO) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs, (retrieved on 6/19/26 from State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities). On 6/15/26 at 4:23 PM, assigned nurse LPN B explained resident #134 had a wound and received antibiotics through a midline IV. The nurse acknowledged due to the midline and wounds that resident #134 should be on isolation precautions. She confirmed there were no signs outside the resident's door nor were there any orders for isolation precautions, earlier that morning when she assumed care. Review of the physician's orders revealed an order was placed on 6/15/26 at 1:50 PM for EBP. On 6/17/26 at 1:30 PM, during a joint interview with the DON, the IP nurse and the Staff Educator/Risk Manager, they acknowledged the order for EBP was not placed until Monday 6/15/26 in the afternoon. They all confirmed the expectation was for EBP to be ordered and implemented upon admission and not five days later. They were unaware of the current care plan that showed an approach for Contact Isolation and said they would look into it. 3. Resident #5 was admitted to the facility on [DATE] with diagnoses to include Klebsiella pneumoniae, urinary tract infection (UTI), and extended spectrum beta lactamase (ESBL) infection. Klebsiella pneumoniae is a type of bacteria that can cause pneumonia, UTIs, wound infections and other illnesses. Some can be severe and hard to treat with antibiotics. Klebsiella naturally lives in your gut and respiratory tract. It most often spreads from person to person or through contaminated medical devices, (retrieved on 6/18/26 from www.myCleveland clinic.org). Extended-spectrum beta-lactamases are enzymes or chemicals produced by germs like certain bacteria. These enzymes make bacterial infections harder to treat with antibiotics, (retrieved on 6/18/26 from www.webmd.com). On 6/15/26 at 1:15 PM, the signage outside resident #5's door indicated the resident was on EBP. The sign detailed PPE was required to be used by staff during high contact activities with the resident. On 6/16/26 at 10:30 AM, the signage outside resident #5's room had been changed to Contact (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105960	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Windermere		STREET ADDRESS, CITY, STATE, ZIP CODE 4875 Cason Cove Drive Orlando, FL 32811	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Isolation. The new sign indicated PPE was required to be used anytime from entrance to the room until exit from the room. On 6/18/26 the signage outside resident #5's room was again changed to EBP. Review of the physician orders on 6/17/26 revealed an order for Contact Isolation (for ESBL) from 6/15/26 to 6/17/26. On 6/18/26 at 11:30 AM, the Infection Preventionist nurse stated, nurses were responsible for the signs being placed for the type of isolation ordered by the physician for the residents. She said that wound or other cultures usually took two days and the results were sent to the physician who might change the orders based on the results. The nurse explained resident #5's culture came back and the EBP was changed to Contact Precautions. She stated it was changed back to EBP on 6/17/26 because resident #5's antibiotics were completed. She confirmed she was not aware resident #5 had a physician order for Contact Precautions from 6/15/26 to 6/17/26. The facility's policy on transmission-based precautions, reviewed 12/08/25 indicated Contact precautions were intended to prevent transmission of pathogens that spread by direct or indirect contact with the resident or the resident's environment. PPE utilized included gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. The facility's policy for Enhanced Barrier Precautions, reviewed 12/08/25 indicated Enhanced Barrier precautions was an approach of targeted gown and glove use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition.		